UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

HEALTHY ADVICE NETWORKS, LLC,	:	
Plaintiff,	:	
vs.	:	Case No. 1:12CV610
CONTEXTMEDIA, INC.,	:	
Defendant.	:	

Deposition of KATIE MERZ, a witness herein, taken by the defendant as upon cross-examination, pursuant to the Federal Rules of Civil Procedure and pursuant to notice of counsel as to the time and place and stipulations hereinafter set forth, at the offices of Keating Muething & Klekamp, PLL, One East Fourth Street, Suite 1400, Cincinnati, Ohio 45202, at 9:30 a.m., Tuesday, March 18, 2014, before ANN M. BELMONT, RPR, a Registered Professional Reporter and Notary Public within and for the State of Ohio.

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APPEARANCES:

On behalf of Plaintiff:

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On behalf of Defendant:

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S T I P U L A T I O N S

It is stipulated by counsel for the respective parties that the deposition of KATIE MERZ, a witness herein, may be taken at this time by the defendant as upon cross-examination and pursuant to the Federal Rules of Civil Procedure and notice to take deposition, all other legal formalities being waived by agreement; that the deposition may be taken in stenotype by the Notary Public Reporter and transcribed by her out of the presence of the witness; that the transcribed deposition was made available to the witness for examination and signature and that signature may be affixed outside the presence of the Notary Public-Court Reporter.

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KATIE MERZ,

a witness herein, of lawful age, having been first duly sworn as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

BY MR. HANKINSON:

Q. Good morning.

A. Morning.

09:39 Q. Would you please state your name and spell your last name.

A. Katie Merz, M-E-R-Z.

Q. Merz?

A. M-E-R-Z.

Q. Very good. Thank you for coming in today. As we established, but I'll say again for the record, my name is Tom Hankinson, I'm an attorney for ContextMedia, which is the defendant in this action. Do you

09:39 understand what case you're here about today?

A. Yes.

Q. And do you understand that your employer is the plaintiff in that case?

A. Yes.

Q. And who is your current employer?
A. PatientPoint.
Q. And did they go by a different name within the past couple of years?
A. Healthy Advice Networks formerly.
Q. Do you know about when that name change happened?
09:40 A. I don't exactly recall. My guess could be three, three or so, four years ago.
Q. Some time ago?
A. Yeah.
Q. And it's the same company, it just changed names?
A. Yes.
Q. Did your employer as a company ever change over the last three or four years?
09:40 A. Did my employer?
Q. Your paycheck's still coming from the same place they always have?
A. Yes, but the name has changed.
Q. And do you understand that

you're here -- have you heard the term 30(b)(6) before?

A. No.

Q. Okay. Do you understand that you're here as a designee of your company on a certain topic?

A. Yes.

Q. And what's your understanding of that topic?

09:41 A. The content of the loops.

Q. And let me back up a step. Have you ever been deposed before?

A. No.

Q. Never been in a deposition?

A. No.

Q. Given testimony in court or anything?

A. No.

Q. Okay. Your lawyer's probably

09:41 explained a lot of this stuff so I won't spend a lot of time on it, but if you ever need a break, please answer any pending question and then just ask for the break, you can have one.

A. Okay.

Q. If you need water or anything, just let us know. If your attorney has an objection to one of my questions, he'll state that, you might want to give him a little time to do so. And after that, unless he instructs you not to answer, you go ahead and answer. Usually those instructions not to answer have to do with what we call

09:42 privilege, so he might say, objection, privilege, then he'll give you an instruction. I don't want to get into information that's actually privileged, so we'll deal with that if and when it comes up.

A. Okay.

Q. Do you understand that?

A. Yes.

Q. And because we're taking all of this down, we have to answer yes or no, some

09:42 kind of word and we'll try to avoid, and I'll try to avoid saying things like uh-huh or nodding or shaking my head, and I would appreciate it if you would as well.

A. Okay.

Q. Okay is a great example.
A. Okay.
Q. And we will try to not talk over each other. It's something that I have a problem with. But we can only get down one person's words at a time. So even though I'm longwinded and I might stop and start and think in the middle of the question, to the extent that you can understand what the heck
09:43 I'm doing, wait until I'm finished with the question and then answer it. Are you okay with that?
A. Yes.
Q. If you don't understand any question, feel free to ask me to repeat it or to ask me to rephrase it and I'll try to do that or figure out why you don't understand it and we'll get to the bottom of it, okay?
A. Okay.
09:43 Q. If you do answer, I'm going to assume that you understood the question; is that fair?
A. Yes.
Q. All right. That sounded very

official. I'm going to hand you what's been marked already as Defendant's Exhibit 1.

(Exhibit 1 identified.)

MR. HANKINSON: Do you need a copy?

MR. BERNAY: Yeah.

MR. HANKINSON: Maybe you should take a copy and the witness can use this full set of what was marked yesterday.

09:44 MR. BERNAY: Okay.

Q. So what I've just put in front of you is a full set of everything that was marked yesterday at the deposition of Greg Robinson. Do you know Greg?

A. Yes.

Q. Is he in your chain of command or your silo at PatientPoint?

A. He is my chief operation officer, or COO.

09:44 Q. And does the person that you report up to report up the chain to him ultimately?

A. No. I report to the chief medical information officer who reports to

the CEO, Tom McGinness.

Q. And who is the chief medical information officer?

A. Geeta Nayyar.

Q. Could you spell that?

A. G-E-E-T-A, N-A-Y-Y-A-R.

Q. Thank you. Is that your direct supervisor or manager?

A. Yes.

09:45 Q. Does she report directly to Tom McGinness?

A. Yes.

Q. What's your title?

A. Vice president editorial and creative.

Q. What are your job duties?

A. I oversee the team of writers and designers who create the content for both our digital and print programs. I also

09:45 oversee the marketing execution team for the sales port materials for the enterprise.

Q. Part of your job deals with the content that is displayed on PatientPoint screens in doctor offices; is that accurate?

A. Yes.

Q. Part of your job deals with the types of marketing materials that PatientPoint uses in order to get those screens placed in doctors' offices; is that right?

A. Yes, yes.

Q. And another part of your job on that side, the marketing side, would that

09:46 also entail the types of materials that PatientPoint uses in order to get advisers and sponsors to pay to have content placed on PatientPoint's networks?

A. Can you rephrase that, please?

Q. Sure. The aspect of your job that deals with marketing materials.

A. Em-hm.

Q. Do some of those marketing materials go to advertisers and sponsors?

09:47 A. Yes.

Q. Is there another department that deals with those marketing materials or it's all in your wheelhouse?

A. Yes, there is another

department.

Q. What's the name of that?

A. The strategy for the marketing materials comes from the clients solutions team for the pharmaceutical sponsors like you just mentioned. And the strategy for the marketing materials to sell into doctors offices comes from the providers sales department.

09:47 Q. The strategy comes in from those two sources, and is your department in charge of executing that strategy?

A. Yes.

Q. You said -- as vice president, what was the word before creative?

A. Editorial.

Q. Editorial and creative. You said you oversee writers and who else?

A. Designers.

09:48 Q. Where would animators come in?

A. Designers.

Q. Are there other types of designers?

A. Print and digital.

Q. How big is your department?
A. Eighteen.
Q. And they report to you?
A. Not all directly.
Q. Are you the head of the department?
A. Yes.
Q. Are there any video designers or editors on your team?
09:49 A. The digital animators or the digital designers, yes. There are several of them.
Q. Several video editors?
A. I'm trying to think what your -- are you asking for the -- can you rephrase the question?
Q. Does anybody shoot videos at PatientPoint?
A. No.
09:49 Q. Does anybody produce videos at PatientPoint?
A. No.
Q. Does anyone at PatientPoint give instructions to a vendor or some sort of

video production company to make videos?

A. Not in the past, we are just about to pursue that.

Q. In what way?

A. We are concepting a new segment that features our CMIO in the series of video segments.

Q. Ms. Nayyar?

A. Yes.

09:50 Q. Is that the only planned video in the works?

MR. BERNAY: Tom, to be clear, are you asking across the entire company?

MR. HANKINSON: Yes.

A. If you mean video by production by a video camera out in the field, then, yes.

Q. What other types?

A. The output of our animated

09:51 segments can be converted into a video file. So meaning a quick time file that would play just like any other video. But those are done not by a video production company.

Q. Any other live action video

besides the segments with Ms. Nayyar?

A. No.

Q. What led to the decision to feature your CMIO in live action video segments?

A. The company wanted to add credibility to our brand by bringing on a certified doctor to serve as a medical expert across all of our content, both print,

09:52 digital, check in all of our programs. That was the impetus for bringing her on and getting her face out there.

Q. Where will that live action video be seen?

A. The starting plan is on the waiting room programs.

Q. What are the different waiting room programs that PatientPoint provides?

A. There are five specialties;

09:52 primary care, OB/GYN, rheumatology, cardiology and dermatology.

Q. Can you say them again for me? Primary care?

A. OB/GYN, which is women's health,

rheumatology, cardiology and dermatology.
Q. What's the value of the credibility of your CMIO and the credibility of the brand that would stem from that?
MR. BERNAY: Object to the form, but you can answer.
A. Can you say it again?
Q. Sure. What's the value of the credibility of the brand under the CMIO?
09:53 MR. BERNAY: Same objection, but you can answer.
A. From a provider's perspective, employing a doctor as an executive adviser across our content goes to ensuring our medical accuracy of all the content we put inside their doctor offices.
Q. When you say from a provider standpoint, are you talking about the doctor's offices in whose waiting rooms
09:55 PatientPoint's content is displayed?
A. Yes.
Q. And so the credibility of PatientPoint as a brand and now the credibility of your CMIO is one factor that a

provider would think about in determining whether to acquire or keep a PatientPoint network in the waiting room; is that accurate?

A. I believe so.

Q. And it's important enough to embark on the production of a live video sequence that will play on all five of the different networks?

09:55 A. Yes.

Q. Do you think, then, that it's calculated to make a material difference in the decisions that the doctors and office managers make about whether to acquire or keep a PatientPoint system in their waiting room? Let me put it differently. You wouldn't do it if you didn't think it would matter, right?

A. Perhaps I would say we are

09:56 testing the impact. We don't know yet.

Q. How will you study the impact?

A. We will gauge the impact like we gauge the impact of feedback from all of our networks, which is primarily through the

relationship management team who is assigned to provider practices as the liaison and is in communications about what they like and don't like about the program.

Q. And you said you get feedback from them on a regular basis?

A. Yes.

Q. It's called the relationship management team?

09:57 A. Yes.

Q. Who heads up that team?

A. Amy Finley.

Q. Is that the same team that reaches out to practices who don't have a waiting room system or have a waiting room system from a competitor to try to place the PatientPoint system?

A. No.

Q. What's the name of that team?

09:57 A. Provider sales.

Q. Who's the head of that?

A. Lee Hambright.

Q. How does the relationship management team gather the information about

what matters to providers to give it to you?

A. They, in any communication they have with the practice, log the substance of that communication in a content or customer management system, and if -- I think that answers the question.

Q. What's the name of that system?

A. Content -- customer management system or CMS.

09:58 Q. Do you usually rely on the entries that the relationship management team makes in the CMS in order to make decisions about what matters to providers as you're designing and changing content?

A. In part.

Q. What other factors?

A. What other factors?

Q. Let me back up actually. You rely on it in part, that means that you rely

09:59 on it and you rely on other things, too?

A. Correct.

Q. Do you think it's reasonable in your profession to rely on the feedback that the relationship management team puts into

CMS in order to make decisions?

A. Yes.

Q. And what other things do you rely on in making decisions about content?

A. General research on the specialties, what types of patients doctors are seeing in the specialties, what's the frequency of different conditions that are being treated in those specialties. We have

10:00 advisory positions that we'll poll for information on what's important to them that we educate on in those programs.

Q. How does that polling work?

A. Usually an e-mail.

Q. To how many people?

A. Depends on the program. But each -- at a minimum, each specialty, digital or print, has a key primary medical adviser that we use as a sounding board.

10:00 Q. Sometimes the poll might be just an e-mail to that medical adviser?

A. Right.

Q. Does it sometimes go more broadly?

A. Yes.
Q. And in the cases where it goes more broadly, who is it going to, how many people and of what type?
A. We may do a focus group of physicians.
Q. Are the members of the focus group drawn from people who already have a PatientPoint system in their waiting room?
10:01 A. Usually.
Q. Are there exceptions?
A. Perhaps.
Q. You're not sure?
A. I'm not sure.
Q. The focus groups that you're aware of, you've never come across someone who didn't already have a PatientPoint or a Healthy Advice system in the waiting room; is that accurate?
10:01 A. Yes, not that I'm aware of.
Q. Is it just your common sense impression that they are made up of people who already have a PatientPoint system?
A. Yes.

Q. Who runs the focus groups?
A. Our research department.
Q. Who do they report to?
A. Scott Nesbitt.
Do you mind if I take a break to get coffee?
MR. HANKINSON: I would love to take a break to get coffee. Go off the record.
10:07 (Break taken.)
Q. Does Scott Nesbitt report to anybody who is in your chain of command at any point?
A. No.
Q. Goes straight up to what, the COO?
A. Scott reports to Lee Hambright, who is our chief commercialization officer.
Q. Who does Lee Hambright report
10:07 to?
A. I believe the CEO.
Q. What's chief commercialization officer mean?
A. In general, I think he -- it's a

role to look for business opportunities for the enterprise at large.

Q. Does the research department also go out to various journal sources and online sources to look for content, or is that held within your group?

A. Within my group.

Q. Are there other types of research that the research department does

10:08 other than content related focus groups and communications with the medical advisers?

A. They don't primarily access the medical advisers, our team does. They do do the focus groups like you mentioned, and they -- while I'm not the expert to speak to everything they do, I am aware that they do ROI research for our sponsors.

Q. What's ROI?

A. Return on investment.

10:09 Q. Does ROI research have an impact on the content that gets displayed?

A. No.

Q. Who does that research go to?

A. The ROI research is done on

behalf of our paying sponsors to show that if they place an advertisement in our programs, that they will pay out. So the summary of those findings are presented to the advertisers after the contract term to get them to renew or to say it did work, it didn't work.

Q. Does the quality of the content impact the return on investment?

10:10 A. I would think so.

Q. For what reasons?

A. It's important to create an engaging and relevant program to get people to watch, and when they watch, they see both the content and the advertising.

Q. So ROI is a measurement of how much they're retaining the advertising part of the programming?

A. In part. ROI for the OTC or

10:10 over-the-counter or CPG, which is consumer package goods, it would be recall. For pharmaceutical sponsors, it would be prescription list.

Q. Those are ways of measuring how

much engagement there was with the content such that it impacted the patient's decisionmaking or retention if they're being polled?

A. Can you say that one more time?

Q. No.

(Record read by Reporter.)

MR. BERNAY: I'll object to the form, but you can answer.

10:11 A. I'm not sure if it equates to a measure of engagement, but indirectly there's a correlation I guess.

Q. If the content is so awful that the patients all look away from it, then ROI would go down?

A. That's the assumption.

Q. And if it's really great so they're all looking at the screen the whole time they're in the waiting room, including

10:12 the bits that are sponsored and that are advertisements, the assumption is that the ROI would go up?

A. Yes.

Q. Is part of your group's -- is

it -- do you refer to it as a team, a group, a department?

A. Team is fine.

Q. Is part of your team's goal to increase ROI?

A. Our team's goal is not primarily focused on that. However, on behalf of our business, of course, we want to have a program that leads to good ROI.

10:13 Q. Because then the company gets paid more?

A. Exactly.

Q. And the company would get paid more, not just by attracting new sponsors and advertisers, but, potentially, if you have high ROI, you can charge higher prices; is that right?

A. I don't know that.

Q. But somehow more money would

10:13 come in the door with increased ROI?

A. I'm not sure if it's more money, but it supports our business model to ensure more longevity.

Q. Keeps everybody from getting

fired?

A. (Witness shrugs shoulders.)

Q. Yes?

A. I guess, yes.

Q. Let me back up way back. Could you run through your education after high school and then the jobs you've held since then.

A. Sure, yes. I went to Xavier
10:14 University for undergrad, F&W Publications, now F&W Media as an editor for Writers Digest Magazine, went back to Xavier for grad school for a master's in education, freelanced as a scientific editor for the Journal of the School of Harvard. Public Health Reports was the name of the journal. I also freelanced at Healthy Advice, and then came on full time at Healthy Advice, now PatientPoint.

Q. How long were you freelancing
10:15 with the Public Health Reports journal?

A. Approximately a year and a half.

Q. Were you freelancing at Healthy Advice Networks during that time or after that time?

A. They overlapped.

Q. When did you start working full time at Healthy Advice?

A. 2006, I believe.

Q. When would you say that you started to work in -- well, do you consider yourself to work in marketing or advertising?

A. Not -- no.

Q. Editorial, what would you

10:16 describe your job as at like a cocktail party? I am in?

A. At this point I would describe it as content development. Editorial, meaning in terms of -- the term editorial means creating content in a nonbiased way. So I would describe what I do as researching relevant topics for stated audiences and applying an expertise to craft the lineup of content or an approach to content that would

10:17 most meaningfully engage that -- those audience members.

Q. And the audience members are the patients in the waiting rooms?

A. In this case.

Q. Are you familiar with -- I mean, what do you look in to to get content other than what the sponsors provide?

A. Do you mean content for the waiting room program in particular?

Q. Yes.

A. We rely on research to the specialty, primarily from government and nonbiased resources, such as the CDC, NIH,

10:18 various associations or foundations that are not for profit; Mayo Clinic, Cleveland Clinic, those kinds of medically recognized authorities.

Q. And what types of output are they giving that you're looking at?

A. Mainly they're online public domain web resources that they make available to patients.

Q. So it's not scientific journal

10:18 articles, but it's from these reputable resources and it's web based. Who are their audiences?

A. Patients, consumers.

Q. Same as yours?

A. Yes.

Q. And some of it's kind of -- go ahead.

A. Sorry, I just want to clarify that all of those organizations probably have documents on their website that are for patients and consumers as well as for providers, but since we work for the audience of patients, that's what we rely on.

10:19 Q. And those types of organizations; the CDC, that's Center for Disease Control?

A. And prevention.

Q. And prevention. And the National Institute of Health, that's NIH?

A. Yes.

Q. Those types of groups, do they engage in public health advocacy?

A. I don't know for sure.

10:20 Q. Do they try to get patients to do things that would make them be more healthy?

A. Yes.

Q. Is that a lot of the content

that PatientPoint gleans from those sources and passes along?

A. Yes.

Q. Including -- I'm thinking of the Ad Council, do you know the Ad Council?

A. Yes.

Q. Do you know if they do health?

A. They do.

Q. They do health-related things.

10:20 So I think of it as like Smokey the Bear. What's the health related stuff that they do?

A. Who?

Q. The Ad Council.

A. We don't use the Ad Council. I wouldn't -- they're not a primary source for us, so I wouldn't feel comfortable speaking to it.

Q. Okay. Well, what are some of the health-related public service

10:20 advertisements that the CDC would put out?

A. The CDC may have created public facing campaigns, perhaps, say, I know of one that I'm familiar with is on autism awareness, about speaking up and noticing

early signs.

Q. Em-hm.

A. But for the purposes of our content generation, a lot of times we're just reading their texts on how to treat COPD versus relying on their CDC campaign on -- perhaps that they may have on COPD.

Q. But it's all facing the patient, right? That's the audience?

10:22 A. Yes.

Q. And just in looking at some of the content, it seems kind of like helpful, like here's a tip to deal with this problem that you have, and here's a list of five things that help with symptoms of this other thing.

A. Are you talking about our content?

Q. Yeah. I'm just trying to get at

10:22 if that's coming from something like the NIH, these are things that are geared toward getting the public to act in more healthy ways?

MR. BERNAY: Object to the form.

A. Yes.

Q. Like one of the things that I've seen from a PatientPoint program would be encouraging screening?

A. (Witness nods head affirmatively.)

Q. Do you happen to know what type of sources that information comes from?

A. It would depend on what

10:23 screening it was. So, say it was the importance of diabetes screening, to research that topic, we may go to -- probably wouldn't rely on just one, but the American Diabetes Association, we'd probably see what the FDA said about that, the American Heart, Lung and Blood Institute say. So part of our content process is a due diligence, scoping out of what the key entities are saying about that screening, and then taking our editorial

10:23 expertise to pull it together into a segment that makes sense for our medium. But we usually primarily source the end of the segment the main research that we relied on.

Q. So some of the content helps get

the word out about things that the FDA or the ADA may be trying to say about patients that, you know, it has a positive health impact if you get this early screening?

A. Correct.

Q. It reminds me, I used to be in college radio, we used to do PSA, like, hey, you should recycle, or you should do this. Is it kind of like that?

10:24 A. You could argue that our entire program is a public service announcement, because we're looking to underscore the relevant health messaging that providers want their patients to hear, and to drive healthier behavior.

Q. That's really interesting. So like the providers want their patients to do these things because they'll feel better and they'll be healthier, right?

10:25 A. (Witness nods head affirmatively.)

Q. Yes?

A. Yes.

Q. And sort of the, some of the

sources that you're talking about, like the CDC, the Mayo Clinic, the NIH, they also want these patients to act in these healthy ways and to get the word out about these programs; is that right?

A. To get the word out about these, the importance of these healthy behaviors, yes.

Q. Thank you for that

10:25 clarification. Interesting to me, like as a business for PatientPoint, you say you add your expertise, so in a way you're helping get that message out. How do you add expertise that sort of makes that happen?

A. Two thoughts come to mind. The first is all of our medical writers are certified through the American Medical Writers Association, so we attend yearly conferences and have applied for

10:26 certification. So that's one.

The second is bringing a consumer-friendly approach to complicated medical information. So leveraging expertise from how -- in particular, my experience in

magazines is used to talk about topics that are not so hard as medicine, and to take those same tools and tricks, say, of the trade, and apply them to health information to help make that more digestible and easy to understand.

Q. And engaging?

A. And engaging.

Q. So that they act on it?

10:26 A. Correct.

Q. And as I'm looking at it, it kind of -- there's some animation, there's some words and maybe the words will kind of -- there will be a sentence and then something will kind of whiz in from the side and knock a word around, and it's something that's kind of -- it's words on a screen, but there's some animation with it. Is that kind of one example how to make these things more

10:27 engaging?

A. I would say the animation technique or approach of how we build the narrative throughout each segment is one way to make things engaging.

Q. Which part of that is the animation?

A. Sometimes we refer to our animation approach as building the narrative. Meaning that you have a text, a script that you could just put the words up on the screen as a -- on a steady clip.

Q. Em-hm.

A. But that's not helping them to
10:28 read or follow along, so we'll take a more intentional approach to bringing in the words and transitioning the words on and off in a way that would help keep -- attract and keep people's eyes on the screen.

Q. When I used to have to do -- you know, like continuing legal education. Do you do continuing education stuff? I don't know. There's like continuing education courses we have to take as lawyers, and I used to have
10:28 to give some at my old firm and I would always have a presentation of what you described, the words were on the page. That would be kind of the wrong way to do it, right? It's kind of boring. It's okay to

insult me.

A. So what are you asking me? I'm sorry.

Q. I mean, could you apply your methods of making things more engaging to, you know, like words on a screen, like I'm trying to convey a legal concept and it might have five bullet points, there's a way to do that that builds the narrative.

10:29 MR. BERNAY: Object to the form. You can answer.

A. I guess I'm struggling to answer it because I feel like they're two separate teaching tools. I mean, it sounds like the thing you're referring to is like a presentation or a PowerPoint versus what we do is just building After Effects or Flash animation. So I'm not sure if the tools and tricks of the Flash animation could be

10:30 translated exactly into that other medium, I don't know.

Q. You're not familiar with, like, presentations software?

A. Not as -- I'm not as an expert

of that as I wish I was.

Q. Right, because it's helpful, right?

A. Yeah.

Q. So this is what I always struggled with, is I know that there are ways to animate text and to add pictures in, for instance, PowerPoint presentations, right?

A. Yes.

10:30 Q. And it sounds like what you're saying is you use Flash?

A. Right.

Q. And some other tools?

A. Correct.

Q. But not live action video except for this thing that's starting with Ms. Nayyar?

A. However, we have -- stock video is available, so we haven't purchased stock

10:31 video that we've used in segments before.

Q. The video would run in the background, there would be some text from you guys in the foreground?

A. In essence, yes.

Q. What's Flash?

A. Flash is a program we use that is an animatics program so it allows the designers to design in a digital space. I would prefer if my design team would explain it. I don't personally work in it day-to-day.

Q. But things on the screen move around based on what they program it to

10:32 Flash?

A. Right, but as I mentioned, Flash is only one of the programs they work in. After Effects is another main tool.

Q. What is that?

A. It's another type of creative suite program for digital design that allows for more robust timelines and insertion of video and photography, and with a more robust suite of tools for transitions and layers.

10:32 Layers, meaning how you build a segment so that it includes video imagery, etc.

(Exhibit 13 identified.)

Q. I'm going to hand you a new document. Flip through that if you would,

it's double-sided. What's been marked as Defendant's Exhibit 13 is a combination of many documents. Each has loop lineup at the start of it. Are you familiar with these loop lineup documents?

A. Yes.

Q. Do you use them in your work?

A. Not in my current role daily.

Q. What did you do to prepare for

10:34 testifying about the content and the duration of content in advertisements in PatientPoint's content loops today?

A. My current role, I'm not as daily -- the daily overseer of this, so I just tried to refresh my memory on the general content, generation flow.

Q. You used to be more directly engaged with that?

A. Yes.

10:35 Q. And so what did you do to refresh your recollection?

A. Mainly, it was a mental exercise of just recalling, okay, this is how -- taking the approach of how a bill becomes a

law. Oh, yes, this starts with this, it goes to that, starts with this, you know.

Q. I'm only a loop.

A. Right, so.

Q. Did you talk to whoever's in charge of it now?

A. No.

Q. Did you review any documents to help refamiliarize yourself with it?

10:36 A. Yes.

Q. Which?

A. I had a folder from when Aaron, when I was --

MR. BERNAY: I would advise you not to disclose the content of conversation with counsel. You can state what documents you reviewed, but not disclose anything that we discussed at any point in time.

A. Okay. I think the documents were

10:36 the ad editorial ratio document was the main one. And you, or Context Health, had at some point asked for certain loops, and I had printouts of those and I glanced at those to see which ones you asked for.

Q. The printouts of the loops?
A. Em-hm.
Q. Were those loop lineup documents?
A. Not loop lineup documents, no. It was the story boards.
Q. What are the story boards?
A. Story boards are this translated into thumbnails.
10:37 Q. Is that done for all loops?
A. Yes.
Q. And thumbnails have, like, a little graphic depiction of what each file is?
A. Yes.
Q. Where are those stored?
A. Hard copy. They may have a digital storage as well. I'm not 100 percent sure.
10:37 Q. So how does a bill become a law? How does a nascent loop go into becoming a final loop?
A. I'm going to try to summarize this. It begins in general with the concept

that a loop is primarily going to be 25 to 30 minutes long. That loop is composed of content, custom messages from the doctor, and sponsor messages. So there's a working editorial lineup of content that is a portion of that loop. However, the loop link is not a finite thing. It is something that expands or contracts based on the number of advertisers that come in. Because the main

10:38 thing we subscribe to is this 30:70 ad to editorial ratio. The 30 percent is sponsor messages, the 70 percent is composed of content plus the personalized messages from the doctor.

So, every month our program management team, who is the team that liaisons with the client sales group to bring in the sponsor content, provides us an output of how many seconds of sponsor content will

10:39 be in that loop's lineup. We then put it into this Excel document that calculates, given the number of seconds of advertising that will happen, the fixed amount of personalized message time that will happen, how much

editorial time do we need to maintain the 30:70 ad/edit ratio. Then we will go in and either -- we often don't subtract content if it's a little extra, but if we're low on the editorial, we will add additional segments until that amount of time of editorial gets us to a comfortable 30:70 ratio.

Q. What's included in the editorial time?

10:40 A. The individual content segments. The personalized messages from the doctor, of which 270 seconds worth appear each loop. And what we call a network identification. So, you're watching PatientPoint.

Q. How much of that is played per loop?

A. Usually appears twice and it's about 10 to 15 seconds.

Q. Would you be surprised if -- as

10:41 I'm watching it, it's 30 seconds long each time?

A. The network ID?

Q. Yeah.

A. It would depend on what network

you're watching. We've revised it, so perhaps if you're referring to one that was -- actually, I have no idea. If -- no, it would not surprise me. We changed it, though, so it could be a longer version or a shorter version.

Q. And you don't know exactly how long it is at any one point in time or on any particular network?

10:41 A. They're the same across the networks. So I know at one point we had a longer version that appeared once and then midway through we had a shorter version. I think -- I believe that now we're playing the same one in both instances in the loop, and that it's about 15 seconds.

Q. If you add other editorial content so that the nonsponsored editorial time is like 45 minutes, would you add an

10:42 additional network identification?

A. Please repeat that.

Q. Generally, it starts out with a skeleton of about 25 to 30 minutes of editorial time?

A. Total loop time.

Q. Oh, total loop time. If you add 10 or 15 minutes of editorial time because you got a lot of sponsored material there, would you typically add a network identification slot?

A. No.

Q. So there would be two?

A. Correct.

10:42 Q. And has that been the case for the last three, four years?

A. I believe so.

Q. But the duration of those network identifications changed at some point?

A. Correct.

Q. The 230 seconds of personalized messages from the practices, is that the same regardless of what the practice gives you?

10:43 MR. BERNAY: I believe she said it was 270 seconds.

A. Each personalized message is 15 seconds in length and there are nine sets of them, they appear in pairs of 30 seconds.

So there's each -- they appear back to back, so if my math is correct, it should be 30 times nine, which is 270.

Q. 270 seconds?

A. Em-hm.

Q. And that's always the same?

A. Yes. If the practice is just utilizing our off-the-shelf practice personalized message option, they have those

10:44 18 opportunities to play a personalized message of 15-second length. However, a few practices are interested in playing their videos, their own practice videos, and we have a mechanism in place for them to do that.

Q. That varies by practice?

A. What varies by practice?

Q. The videos that the practices play.

10:44 A. Yes. And they -- that -- the business model for that is, if they want to play their videos, they have two opportunities in the loop to play those videos. And they can be no longer than three

minutes in length. Those are definitely the exception, but those segments count toward editorial time.

Q. Would you look at what's been marked as Defendant's Exhibit 13, the first page, which in the lower right there's an HAN 0002707, we call those Bates numbers, I might refer to them here today. They're added usually by counsel when they're providing

10:45 documents to the other side so that we have a uniform system of page numbering. So if you could look at the page 2707. Do you see the column? It's the second column from the left, it says Seq. Order?

A. Yes.

Q. Are you familiar with what that means?

A. Yes.

Q. What does it mean?

10:46 A. It's the abbreviation, means sequence order. That column is used to denote a functionality in our loop where we can stack content. Meaning that, say there were three pieces of editorial playing in a row,

A, B, and C. A would be the file, the technology displays the file verbatim. B would be a sequence container where we have a variety of editorials stacked in there. And C would be a normal play. Every time the loop would cycle through, when it would get to B, it would play the first time through, the first editorial piece of that slot, the second time through, the second editorial
10:47 piece in that slot, the third time through, in this case, back to the first, because there's only two stacked in there.

Q. What does the 0 mean?

A. That's just -- 0 is the name of the slot file that pulls the -- that is the sequence container itself, so it's a shell with the code inside of it to say play one, play two.

Q. If I look at the row that has
10:47 the 0 in it, it has a slot that's called arth-other II. It has an ID, 2038, that's different from the ID in the row that has a 1 and a 2 beneath it. It has a file name that's different. And then the SWF time is 55. Is

that a file or not?

A. Are you referring to the time 55 for the 2038?

Q. Yeah.

A. Okay. In trying to calculate the time, the editorial time, the slot is where we would put the time we're counting for the master editorial count, so usually it's an average of whatever files are in that

10:48 container.

Q. And how do I tell what files are in the slot?

A. So they're all -- if you look in the slot, all things that are marked arth-other II are part of that sequence container, and if you look over to where -- this is the key thing. On the far right where there's an exclusion, you see how the arth-other II slot is not filled in?

10:49 Q. Em-hm.

A. Whereas, the files underneath it are? That's the way we do that, is so that it's an exclusion, meaning we're only counting that time once, I guess is what I

was trying to say. So those files are excluded, meaning they are part of that play code that will say when it's playing and when it's directed to. So this document here is used to help calculate editorial time, so we don't want to count the 55, the 57 and the 55, we don't want to overcount that, so we take an average usually and we just assign it to the slot itself and not count the
10:50 individual time segments inside that slot so we don't overcalculate. Does that make sense?

Q. No. What are the exclusions excluded from?

A. The exclusions is a technical term. It's a technical term for -- that's tied into the slot loader technology. So meaning we push those files out, but they're excluded until they're told to play.

Q. I thought you said that the
10:50 exclusion comment had to do with how the editorial time was calculated?

A. It does too.

Q. So how does it play into that, and I know you already tried to say it, but I

apologize, I couldn't follow it.

A. I understand, okay. So give me a second. I'm trying to think of the best way to illustrate this for you. So, if you turn to like 0002885, just randomly picked.

Q. Okay.

A. You can see that this document in general shows editorial content which starts on page 1, and then on the backside,

10:52 you'll see there's a summary bar, that says editorial. It also includes a network section which those files denote are network IDs, as well as placeholders for custom messages and then ads. So if you look at this document in general, you can see that, for every file that comes in, there's a swift time allocated to it. This file maker file has logic in it that helps automate that summary of the swift time. So, for example, with PCNA here, you

10:53 have one, two, three, four different segments that are going to be cycling through in that slot. So those calculations or those files have the dots filled in on exclusion, so that when the automated timing of this report is

pulled, it won't count all those extra editorial times. It's only going to count the ones that have the 0s or the exclusion circles not filled in. So for PCNA, we were averaging a 55 second time for that.

Q. So for any given time that a loop plays, the amount of editorial time could be somewhat less or somewhat more, depending on which one of those four is

10:54 playing?

A. Correct.

Q. And that would be the case for any files that have a sequence order number and a 0 in that sequence order column?

A. Correct.

Q. When there's a blank SWF time, what does that mean?

A. Well, PCN is our trickiest loop because there's more than one -- at this

10:55 time, there was more than one PCN loop pushed. So what we would do is build, for example -- again, it all comes down to how many sponsors are in and where they're going. So, say a sponsor only bought a subset of

PCN, they wouldn't buy the whole universe, they wouldn't need to push that file, or we wouldn't want that file to play everywhere because they didn't buy those other locations to play. So we would have to, though, account for that ad time regardless to build our editorial lineup, because at the time we didn't have a way to differentiate that, we could only build one editorial loop to rule them all, so to speak, so we would have to build it off the most -- the largest sponsor amount number.

10:56

10:56

Q. So what does it mean when there's a blank in a SWF time?

A. So for this -- if there's a blank here, which I think you mean this 0 for the PCNB, it means that -- never will a slot PCNA and PCNB, would ever play in the same loop. They're either going to play A or B, so from an accounting perspective, we don't want to count the B.

Q. You would only count the A?

A. Right.

Q. And if B has a -- some of the

slots in B have a different length, they would just be accounted for, nevertheless, by counting what you're putting in slot A?

A. Correct.

Q. Now, that's a very -- thank you for telling me that. I was actually asking what about when there's a blank SWF time, not a 0.

MR. BERNAY: Do you have an example, Tom?

10:57

Q. Do you know the answer to my question?

A. I don't offhand.

Q. Would you look at the page that's marked HAN002723. Do you see that some of those SWF times are blank?

A. Yes.

Q. What is the reason for that?

A. Okay. The reason for the 1331 through 1335 files, why there's only a time for the first one is because, again, it has to do with this sequence exclusion technology. That 1331 file is a designation of our custom messages. And during that time

10:58

we pulled in different video backgrounds for each time it played, so those variances of the background one, background two, that's what BG stands for, background four, background five, that's really just a denotion of the file that we're pushing, that gets called in a different video background each time. So it's not counted as extra time each time because the one master, so to
10:59 speak, of the BG1 is the time.

Q. Would you look at the next page, HAN002724.

A. Okay.

Q. Here there are four ads that have a blank SWF time. It doesn't appear to me that the explanation you just gave for the custom applies to this. How do you explain what these blank SWF times mean?

A. The explanation I just gave you
11:00 I do not believe applies to this. I would probably say that this is a result of someone on our team not backfilling this data entry here. We get the sponsor counts in a separate Excel file, that's where we get the read out

of how many advertisers here, and then we use that file to pull it into this document. And I would say that she just did not go back in and fill those in. That's my best explanation for that.

Q. Would that be the same explanation for HAN002726 where we see MedCenter and Quest with the blank SWF times?

MR. BERNAY: Right there.

11:02 A. I don't -- I don't know.

Q. Do you have another explanation? It seems like the same phenomenon.

A. Probably.

Q. Would you flip to HAN002919. I suggest you treat it like a book.

A. Okay.

Q. And then it'll be good.

A. So don't unclip?

Q. Well, you can unclip it, but

11:03 flip it right to left like you're flipping a book's pages, then they'll stay in order.

A. Okay. 2919?

Q. Yes.

A. Okay.

Q. Is each loop lineup particular to a network and a month?
A. Correct.
Q. And so is the loop lineup that starts at 2919 for PCN, that's primary care network in November 2012?
A. Right.
Q. And I can make that conclusion by reading the title and the date in the
11:03 little strip that's just underneath where it says loop lineup?
A. Right.
Q. Is that going to be true for all examples of loop lineup documents? That's where the network and the date will appear?
A. Right.
Q. And the files under slot and file name are kind of the movie files or other files that are playing when the content
11:04 is displaying in the waiting rooms?
A. Yes.
Q. So if we go down, like, file name and title, we can kind of see that -- you used the word thumbnails before, but just

basically get an idea of what these slots have to do with, for instance, pharmacy pick up, shake your salt habit, cold and flu tips. Is that basically a title for what file is going to play?

A. Correct.

Q. So for cold and flu tips, it would kind of be like one of those public service announcements that we discussed

11:04 before where there's little tips about how to avoid cold and flu, wash your hands for 30 seconds, sing happy birthday while you do it, that kind of thing?

A. Yes.

Q. If you flip to the next page, marked 2920, there's one for meningitis vaccine and one for immunization generally that looks like they play just one place per loop; is that right?

11:05 A. One place per loop cycle.

Q. Right. And those would be related to, for instance, encouraging people to get those vaccines and to be immunized?

A. Correct.

Q. Then if we go down, there's one that says NHO: American, November is lung and National Alzheimer's, are those slots related to, like, lung cancer awareness month or Alzheimer's awareness day, things like that?

A. Correct.

Q. So trying to get the word out to the public about those occasions?

A. Yes.

11:06 Q. Then if we move down, there's something that says "daily aspirin," and it actually appears a few times. ID 2471 says, "daily aspirin and," oh, it's over and over again, I'm sorry. It's all ID 2471, but it appears four times; is that right?

A. It appears four times on this page.

Q. But it's broken out because you're pushing different things to PCNA

11:06 versus PCNB?

A. Exactly.

Q. That's some sort of daily aspirin, like you can take a daily aspirin to control your blood pressure?

A. Right. It's a message about whether or not you should ask your doctor about whether daily aspirin could help you.

Q. And that's all under -- well, I guess, it's over the bar that says "editorial," but, basically, everything that comes above the bar that says "editorial" on 2921 is considered editorial content?

A. Right.

11:07 Q. Then between that bar that says "editorial" and the bar that says "other" that's custom network and network identification?

A. Right.

Q. That's considered editorial time in your ratios?

A. Yes.

Q. And then below that where it says "ads" and then there's a bar that says

11:07 "ads" you call it a summary bar?

A. Right.

Q. That's where it's sponsor content, correct?

A. Yes.

Q. And in the calculating, what you say is the 30:70 ad to content ratio, what you consider ads are what's in this ad section, the things that actually companies pay for, correct?

A. Right.

Q. You're not including in the ad time when you do that 70:30 calculation public service announcements about aspirin or

11:08 flu vaccines or meningitis vaccines?

A. No.

Q. No, you're not counting them or my question was wrong?

A. No, you're not counting them. We're not counting them.

Q. Those would nevertheless be part of the 70 percent that you're shooting for?

A. Right.

Q. I'm going to hand you --

11:09 MR. BERNAY: We've been going about an hour. Do you want to take a break?

MR. HANKINSON: Sure.

(Break taken.)

Q. I saw a piece with Danica

Patrick in it when I was viewing content, it had to do with mammograms. Does that ring any bells?

A. With who?

Q. With Danica Patrick, the race car driver.

A. No.

Q. I'm just curious. Very quickly, I'm handing you a document that we're going to mark as Exhibit 14. Is this one of those ad ratio worksheets that you mentioned earlier?

(Exhibit 14 identified.)

A. Correct.

Q. Do they all look essentially like this?

A. In essence, yes.

Q. And the input where you get the seconds comes from the loop lineup documents that we were just looking at?

A. They come from two sources. The ad seconds come from a Excel spreadsheet provided to us by the program management team. The editorial seconds are calculated

from the loop lineups that we just reviewed.

Q. So from just looking at the loop lineups, and knowing that it looks like there wasn't a complete meshing back with the Excel spreadsheets from the program management team, I couldn't look at those loop lineups and see all the backup for the seconds that are on this ad ratio worksheet, right?

MR. BERNAY: Object to the form.

11:16 You can answer.

A. Not in total, you would need both documents.

Q. What's underneath this redacted part? Do you know what redacted means?

A. No.

Q. Redacted is something that attorneys put on -- a piece of paper when they're covering over something that's in it. Are you familiar with ad ratio worksheets?

11:16 A. Yes.

Q. Can you describe for me what's underneath the redaction of the section of the document?

A. Are you saying there was text or

something underneath here?

Q. Yes.

A. I do not recall.

Q. Is there any information --

A. Oh --

Q. -- that's usually in an ad ratio?

A. I answered too early. Yes, I know what was under there. It just took me a

11:17 minute. This document is used to calculate the -- and test the 30:70 ad ratio across all of our networks, and your team had only asked for information on ACNP and PCNB, so what is under here is the same worksheet work for WHN and SCN.

Q. Setting aside what my team asked for, what's underneath there is for the other two networks?

A. Correct.

11:17 Q. Anything else that would be underneath there?

A. Not that I recall.

Q. I'm going to hand you what we are going to mark as Defendant's Exhibit 15.

Is this an e-mail from Amy Finley to Liz Phillips and you dated June 18, 2012?

(Exhibit 15 identified.)

A. Yes.

Q. Does it forward an e-mail from Deborah K. Adams to Lori Smith?

A. Yes.

Q. Who is Deborah Adams?

A. I don't recall.

11:19 Q. Who is Lori Smith?

A. I believe she's a member of the relationship management team.

Q. And you mentioned previously that Amy Finley heads up that team?

A. Correct.

Q. Is this an example of the relationship management team passing along information of -- excuse me, let me start again.

11:19 Is Defendant's Exhibit 15 an example of the relationship management team passing along feedback about PatientPoint content to your team?

A. Yes.

Q. Can we conclude from this that Deborah Adams is a member of the relationship management team?

A. I would assume.

Q. You can't think of anyone else who would be passing along this type of information; is that correct?

A. Correct.

Q. Does --

11:21 A. Oh --

Q. -- this paragraph here have -- look like a CMS entry that's being put into an e-mail?

A. I would just want to clarify that in response to my last question. Because I don't recall who this person is perhaps it's a provider sales team member. I don't know.

Q. Are you more closely familiar

11:21 with the relationship management team?

A. Correct.

Q. Both the relationship management team and the provider sales team have conversations with doctors offices?

A. Correct.
Q. Please look at the sentence or the words in this paragraph -- let me start again. Are entries into CMS often phrased as summaries of calls with providers?
A. I believe so.
Q. Does this appear to be a summary of a call with a provider?
A. Yes.
11:22 Q. And it begins the comment, "Called and spoke to Tara," is that right?
A. That's what it says here.
Q. And is this the type of description in CMS or passed along by e-mail that your team would use to understand the feedback about content that's coming from -- usually, the relationship management team, sometimes the provider sales team?
A. It is an example.
11:23 Q. And that sort of feedback would be used by your team in designing PatientPoint's content for waiting room systems?
A. Not necessarily. We receive, as

a matter of course of business, there's a sort of a general feedback e-mail distribution list where this kind of comment from customers are just sent along, which we may or may not respond to.

Q. You sometimes respond?

A. Sometimes, yes.

Q. And you sometimes respond in the way that you design content?

11:23 A. It's a factor perhaps.

Q. Well, it's certainly a factor.

A. Right.

Q. This particular comment says, "Said that they liked the monitor better, 90-minute loop, they have cooking segments and sound." Is that the portion of this comment that would be relevant to your team?

A. Yes.

Q. And have you heard -- and this

11:24 is talking, actually, when they say they, they're talking about RHN. Do you know what RHN means?

A. I believe it stands for Rheumatology Health Network.

Q. Is that a competitor of PatientPoint?
A. Correct.
Q. So this comment's being passed along to you. It's actually about the content that a competitor has in a waiting room system?
A. Right.
Q. Is that something -- why do you
11:25 care about what competitors have?
A. Isn't that -- to me, understanding your marketplace and competition is just a commonsense approach to being -- building a product, so.
Q. It's so obvious that it's important to your design that you're having trouble articulating why it's important?
A. Exactly.
Q. The cooking segments. Have you
11:25 heard feedback about competitors having cooking segments aside from just this e-mail?
A. Probably.
Q. Have you heard feedback about competitors having sound aside from just in

this e-mail?

A. Yes.

Q. And is this standing out to the person taking the comments because PatientPoint, at this point, did not have cooking segments or sound?

A. I don't know why its standing out to them, but we have had minimal sound, and I'm not sure if we were including recipe segments at this time or not.

11:26

Q. At some point PatientPoint began including recipe segments?

A. The recipe segment I'm referring to doesn't actually show recipes on the screen, it's a QR code to download them on your mobile phone. So it's not necessarily a recipe segment, but -- I can't remember if that answered your question.

Q. I was just trying not to cut you off. I think so, basically, those QR --

11:27

A. QR codes.

Q. Those QR codes to download a recipe, they weren't part of the content at one point, then you started putting them in

later on?

A. Sure, yes.

Q. Was that in response to feedback like this?

A. I don't recall exactly, but probably in part.

Q. Why does PatientPoint change the type of content that it offers over time?

A. I think any type of content

11:27 program evolves over time. We want to introduce new segments to keep it fresh, you know, for the patients, yes, but also for the provider experience, that they can see that they didn't just purchase something that's up and is never changing, but it's evolving over time, that responds to requests that they have, that is continually trying to push itself to provide innovative, engaging segments.

11:28 So, for example, with the one I just mentioned, you know, the idea of using a QR code was more in response to the mobile insurgence of usage and we were experimenting with could we up engagement with our

programming by offering more mobile segments. So the QR code for recipes was one technique. We had a quiz, a poll with where you could SMS text responses, and those are the two I recall right now that were couched in a mobile engagement experiment on our end.

Q. So increasing engagement with the patient in the waiting room can help please the provider because they like how the

11:29 patients are interacting with the network, and it can also help in terms of retention by the patients and potentially ROI?

A. Yes.

Q. And why do you care as a company about whether the provider likes or dislikes what's on the system?

A. Well, I'll speak from my perspective. I think it's -- this is something I say often, we take the

11:29 responsibility of being invited into the doctor's space very seriously. We understand that we are not the CDC, we are PatientPoint and we need to make sure that they can trust us to give them reliable health information

that comes from nonbiased sources, that we maintain our editorial integrity, that we're not going to be pushing health messaging that doesn't align with what they subscribe to or believe, but, in fact, are a reinforcing tool for them. They only have a limited amount of time with their patients each day, so if we can hit on some topics like general lifestyle, messaging, compliance education,
11:30 that they can glean in that few minutes that they are in the waiting room and perhaps hopefully make a better health decision based off of that, that's where -- that's our goal.

Q. And screening actually goes up when you have messaging related to that, right?

A. We hope. And we did do research on the impact of our screening segments and whether they actually netted out in a higher
11:31 incidence of screenings before, which was favorable research, but I would really defer to someone in the research department to speak to the numbers in particular.

Q. But it's an example of where you

added content related to trying to get the patients to do something and then you looked at whether they actually did it and got a favorable result?

A. Yes.

Q. Oh, and if the doctors don't feel comfortable with your content and don't like it, there's competition in this industry, right?

11:31 A. Yes. But, also, we can respond. Say, for example, a certain customer -- and this is another reason why we have the relationship management team in place. If a customer does not like a certain segment, we have this often with birth control segments in practices that are Catholic or have the certain religious affinity, we, from a technological perspective, can exclude that segment from playing there.

11:32 Q. Is that a feature that practices like?

A. I don't know. It's not something we broadly solicit, it's just a tool we have to respond to when it happens.

Q. Do you think that PatientPoint content has improved over time?
A. Yes.
Q. Is that in response to competition in the marketplace in part?
A. I don't think so.
Q. How many competitors are you aware of?
A. Several. I know our biggest are
11:33 Context Health and Accent Health, but I think Catalina Health is a player, and maybe a few other minor ones. Health Monitor.
Q. Would you say it's a highly competitive field?
A. Yeah.
Q. Do you get feedback from executives about the need to compete effectively with PatientPoint competitors?
A. Are you speaking now or at
11:33 that -- just in general since my whole time being there?
Q. Yeah, if it's changed over time, I'd like to hear how.
A. Well, I'm on the executive team

now so I have more interface with the executives now about that kind of feedback, so, yes.

Q. And can you describe it?

A. Describe, say that again. I'm sorry, like?

Q. Well, you said you get feedback from the executive team about the importance of content to competing with the competitors in the field. And you said you got feedback about that now more that you're on that team and I'd like you to describe that feedback.

A. Just, you know, I would say, given the changing health industry, meaning meaningful use, to the importance of health IT, the importance of making our content fire on all cylinders, especially in light of the new industry, that there's a lot more talk about, you know, how can our content be used as a tool for providers for meaningful use, too. That's more of the feedback that's coming to me right now in our content. Can we certify our content or put it into our technology in a way that would help make it

11:34

11:35

tie into meaningful use, too, which is like a big issue with providers right now. I think that, from a market perspective, that all patient engagement companies are probably faced with that same turning of the tides and trying to figure out how to convert what they do to be meaningful in that way.

Q. And if you don't adapt in this marketplace, then the subscriptions by

11:36 providers would go down?

A. Perhaps.

Q. And indeed some providers change to just regular television, right?

A. Some providers do opt for television as a reason for leaving us.

Q. And that's presumably related to the content shown on television versus the content that's shown on your network?

A. My understanding is that those

11:36 providers don't value, think it's valuable to educate in the waiting room, they just want to entertain their patients and not stress them out.

Q. And they make decisions on that

basis about whether to keep the waiting room system in the waiting room or switch to TV?

A. Yes.

Q. And the providers who do care about engaging their patients in the waiting room are going to be seeking the best way to do that, right?

A. I would think so, yes.

Q. And so it might include looking

11:37 at competitors if they think the competitor's doing a better job, they would go with that service, right?

A. Right.

Q. So one factor why your content would improve over time is to keep that level of trust and positive feedback going with the subscribers so that you can keep the subscription numbers up?

A. Right.

11:37 (Exhibit 16 identified.)

Q. I'm going to show you what we're marking as Defendant's Exhibit 16. I'm going to ask you to look at page HAN 00145, beginning midway down. Do you see an e-mail

from Jill Brewer dated September 9, 2011, where you and Liz Phillips are cc'd and some other people are the on to line?

A. Yes.

Q. The title of this forward is RHN?

A. Correct.

Q. And that is, you said, Rheumatology Health Network?

11:38 A. Yes.

Q. Do you understand that's the defendant in this case, Context's network --

A. Yes.

Q. -- at the time? Jill Brewer says, "As you guys know, we are battling it out with RHN and Health Monitor on a daily basis now," do you see that?

A. Yes.

Q. Were you aware of that at the

11:38 time?

A. Probably via this e-mail.

Q. Jill Brewer is forwarding an e-mail from Diane Feyrer, F-E-Y-R-E-R. Do you know who that is?

A. I do not.

Q. Do you know any of the people on the to line?

A. I know Lisa Grippo to be, I believe, a former member of the provider sales team.

Q. And Amy Finley, who's on the cc line, is the head of the relationship management team?

11:39 A. Right.

Q. Do you happen to recall reading this e-mail?

A. No, I don't recall reading it. I don't recall receiving this e-mail in the past.

Q. If you could look at Ms. Feyrer's first numbered point on page 146.

A. Yes.

Q. "RHN - Sound VS. HA - No sound.

11:41 ACN is designed to be virtually silent. No distractions, TV or other program can be utilized," do you see that?

A. Yes.

Q. That's true, right? You said

that Healthy Advice's content has -- I think you said essentially no sound?

A. Virtually silent is the term.

Q. Virtually silent. And that's actually used to differentiate Healthy Advice's content from a competitor's content?

A. At this time, yeah.

Q. Is that changing?

A. Right. We're considering

11:41 offering a sound and no sound option to customers.

Q. To please the ones who would like sound but keep customers who would prefer no sound?

A. Correct.

Q. Presumably, if you're thinking about offering that option, it's something that matters to the practices?

A. Right.

11:42 Q. It's something that could cause them to decide to go with one system or another?

A. Yes.

Q. Do you have any way to judge how

important that factor is, sounds versus no sound to all the other things that could go into that the decision, like certified content and the quality of the animation and the engagement of the customers, how important that sound versus nonsound is versus all the other factors?

A. Do I have a way to judge?

Q. Yeah.

11:43 A. Not that I can -- I don't know of a way to weigh, from the practice's perspective, which would be more important.

Q. So there's no basis to decide whether that's more or less important than some of the other factors that I mentioned in a decision about whether to keep a network system in the waiting room?

A. The only way to gauge would be when we do lose customers, we keep track of,

11:43 like, reasons why they're moving to other practices, so you could pull that data and look at the reasons that they stated and perhaps run some math to see, you know, how many left for the reason of sound versus they

thought this content was more legitimate versus they thought this content was -- they just wanted television for entertainment.

Q. And those entries are in the CMS?

A. Correct.

Q. Is that something that your group does?

A. Yes, we care very much why we lose customers.

Q. So you look at the CMS data to make conclusions?

A. I am not in CMS on a daily basis. I would say maybe annually we look at it.

Q. Who looks at it when you do?

A. Well, Amy Finley owns that data and the relationship. So, like I mentioned, we have a steady stream of e-mails which we are copied on as a way to get a read of what people like and don't like. We also get e-mails about what people like. And then, you know, there's reports that can be pulled from CMS on data about what, you know, why people

are choosing us, why people are not choosing us, etc.

Q. That's what your group would rely on when you're taking that feedback into account in order to figure out how to change or keep PatientPoint programming?

A. It would be -- right, one factor along with, I mentioned, you know, maybe focus groups with patients and/or providers,

11:45 general creative bills based on maybe what other people are doing in other media or television, mobile, that kind of thing.

Q. And that's the one -- the focus groups and the CMS database are the two sources of ideas that actually take feedback from providers and give that feedback to your team in terms of generating and choosing to retain types of content?

A. Yes.

11:46 Q. Does PatientPoint's content include, like, quizzes? I saw one about the fiber and raspberries.

A. Yes.

Q. Is that something that generally

there could be a quiz as part of the editorial time?

A. Right.

Q. Like quizzes about, like, trivia that's related to health probably?

A. Right.

Q. When did PatientPoint add the ability for a provider to opt out of a certain segment of content?

11:46 A. I don't recall exactly.

Q. Did it get added at a certain time while you were with the company?

A. I believe that technology was -- that capability was always there during my entire time there.

Q. But it's not something that's advertised to the customers, it's just something that you use in reaction when somebody complains about a segment?

11:47 A. Right.

Q. In general, the service that you offer of customization refers exclusively to adding nine 30-second slots or 18 50-second slots of customized provider provided

messages?

A. Right.

Q. Are you familiar at all with the enrollment forms that PatientPoint uses?

A. Not particularly.

MR. HANKINSON: Can we take a break?

THE WITNESS: Sure.

(Break taken.)

11:54 Q. What was the other tool that you mentioned besides Flash earlier for animation?

A. After Effects.

Q. After Effects. Who puts that out?

A. You mean who is the maker of it?

Q. Yeah.

A. I don't know.

Q. It's a suite of animation tools?

11:54 A. Yes, it's a software.

Q. Looking at the loops that were provided, what I see are like a -- it's kind of like -- it's text that could fit on half a page, but it kind of folds out over time.

A. Em-hm.
Q. Is that what you mean by building the narrative?
A. Yes.
Q. So it might be something like there's five ways to lower your blood pressure, but it takes, like, a little bit, there's five ways up in the upper left, and then there might be, like, some orange shapes
11:55 moving in the background, that kind of look like people, and then in from the right flies, like, to lower your blood pressure, and then it might change background and a word appears that's, like, listen to our favorite song, it shows a picture of like a record player.
A. Em-hm.
Q. You're with me so far?
A. Yes.
11:55 Q. Is that, which tool, Flash or Back Up Effects or both are providing those kinds of features?
MR. BERNAY: I'll object to the form, but you can answer.

MR. HANKINSON: What's wrong with that question?

MR. BERNAY: It's the greatest question.

A. I believe either tool could do that.

Q. It's Adobe, Adobe Flash?

A. Yes.

Q. Anyway, it's Flash?

11:56 A. Right.

Q. That could do it or this other tool, Back Up Effects?

A. After Effects.

Q. After Effects could do that as well?

A. Em-hm.

Q. You start with a script?

A. Yes.

Q. And is the script usually less

11:56 than a page?

A. Yes.

Q. And then to build the narrative you kind of divvy up the script, right?

A. Right.

Q. You kind of choose words that are going to appear first, words that will be added with the same background, then at some point you might change the background?

A. Yes. Go ahead.

Q. So over the course of the segment that might be 30 seconds to two minutes long, all the words in the script will get put on the screen, but it's just some at a time and it kind of builds; is that fair to say?

11:57

A. Yes.

Q. The animation consists sometimes of the background shapes moving around, right?

A. Yes.

Q. And then other times it might be -- I'm trying to think how to describe it. It's not quite a cartoon, it's not like there are characters that are walking around and saying things in speech bubbles, but sometimes there's human forms or putting their -- like hand under their chin in the background. Do you know what I'm talking

11:57

about?

A. I am not sure. I mean.

Q. Do you have a word that you use for the kind of animation that you do?

A. The kind of animation? Animation.

Q. Fair enough. So shapes moving around?

A. No. I would say after a script

11:58 is written and it's passed off to design, the designer can pull in photography, stock photography, stock video, can do information graphics, can -- may just play with text and words, there's a variety of ways to, for lack of a better word, illustrate visually that script concept.

Q. Em-hm.

A. So usually the editor and writer try to pick a design approach that's

11:59 appropriate for the substance of the segment.

Q. Okay. And are those all the sources from which that designer can pull from the animation part?

A. You mean sources for visuals?

Q. Yes.
A. I believe so.
Q. Stock photos and original design designs there that are kind of stock designs, what else?
A. Well, we rely on stock photography houses for images, stock video houses for video clips. We might borrow illustrative or borrow -- use illustrative
11:59 icons from stock houses as well. Or our designers inhouse may, in some cases, they have shot their own homegrown video or illustrate them custom themselves.
Q. Okay. Now, when I do a presentation, I can pull a photo. I've done this, I shouldn't admit this as a former IT litigator, but I've gone to Google Images and I've copied a photograph that appears there and I've put it on a PowerPoint slide.
12:00 That's something a PowerPoint could do, right?
A. Yes. I believe PowerPoint can insert photography, yes.
Q. Now, it's easier to manage with

these tools?

A. Easier to manage what? I'm --

Q. With Flash and with After Effects, you're managing a whole kind of narrative build. You use something like that because it's -- you can manage it along with all these other elements that we're going to go through?

MR. BERNAY: Object to the form.

12:01 You can answer.

A. I'm sorry, I'm just confused by the term "manage it."

Q. Okay.

A. So can you rephrase perhaps?

Q. Maybe I'll go through them. So then video, you can insert a video into a PowerPoint slide as well and then play it during the presentation, right?

A. Yes.

12:01 Q. And then you can display words on the same slide as a photo or a video, right?

A. In PowerPoint?

Q. Yeah, in PowerPoint.

A. Yes.

Q. The same is true for icons, which in a sense, are just similar to photo files, you can put icons on a PowerPoint slide, right?

A. Correct.

Q. And PowerPoint actually, amazingly to me, has animation features where icons can move around on the screen, right?

12:01 A. Yes.

Q. And you can also in PowerPoint make the words that are on the screen fly in or fly off or fade in or fade out, right?

A. In PowerPoint?

Q. Right.

A. Yes.

Q. And if I make an original design using some other program, maybe I draw it, as long as I put it in a format that PowerPoint

12:02 can import, I can put that on a slide in PowerPoint, correct?

A. I would assume.

Q. And if I shoot homemade video, again, as long as I have it in a format that

PowerPoint can import, I can put that in a PowerPoint presentation?

A. Right.

Q. So when I'm talking about management, I'm just saying it looks like what Flash and After Effects do is better manage all of those feature so that you can do it a little better in terms of making your content?

12:03 A. To me, they are totally different tools for usage, so it's hard for me to respond I guess. I would think of it in terms of what we do is more of, say, for example, you're watching TV and there's an ad for a truck that relies on graphic animation, and there's not a human in it, perhaps, on this commercial, but they're using, you know, key words that pounded with, you know, images that come in and interact with the text, and

12:03 I'm thinking of what we do is more akin to that, than in terms of as a tool for communicating to people in a digital signage manner versus PowerPoint.

Q. It's different software?

A. It is different software.

Q. The features that I mentioned can be accomplished in PowerPoint, right?

A. Yeah.

Q. Aside from managing it or, you know, designing it from the ground up in a way that is customary to production of advertisements, is there a difference in kind that I'm missing between Flash and After

12:04 Effects and PowerPoint?

A. Can you say that again?

Q. Well, if the features are available in PowerPoint, all I'm hearing is that After Effects and Flash are kind of looked at differently, they have a different way of building it from the ground up. And I'm asking you if there's a difference in kind, or if it's just a difference in speed and ease?

12:05 A. Difference in kind. That's what's confusing me. I don't know what you mean by difference in kind.

Q. You're not aware of a difference in kind between PowerPoint and Flash and

After Effects?

MR. BERNAY: Object to the form. You can answer.

A. The programs that we work in, After Effects and Flash, have a capability of a timeline and layers, so there's a substantive difference between the software mechanism of those programs versus PowerPoint.

12:05 Q. If I took a PowerPoint presentation and I added enough slides and I made it into a flip book, it would be analogous to what you're doing, right?

A. No, because it's missing the layers and timing features. Layers means that -- PowerPoint does not have the capability of putting things into a three-dimensional space unless you were to insert a three-dimensional video inside of

12:06 it, correct? So After Effects allows you to put layers, on one layer you could have the video be playing while the text is on top of it. While the color background -- it just allows for the creation of a

three-dimensional space, so to speak.

Q. The title would go up above the video on a PowerPoint slide?

A. It's more one-dimensional in my mind.

MR. HANKINSON: I think that's all I have.

MR. BERNAY: No questions for me. We'll reserve signature.

_____

KATIE MERZ

* * *

(DEPOSITION CONCLUDED AT 12:06 p.m.)

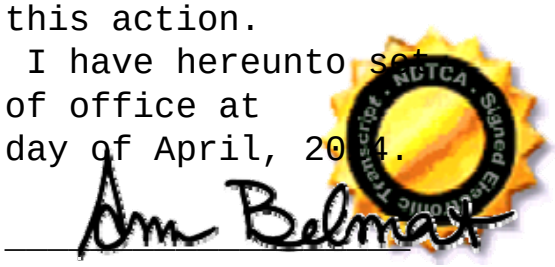
* * *

C E R T I F I C A T E

STATE OF OHIO
: SS
COUNTY OF CLERMONT

I, ANN M. BELMONT, RPR, the undersigned, a duly qualified notary public within and for the State of Ohio, do hereby certify that KATIE MERZ was by me first duly sworn to depose the truth and nothing but the truth; foregoing is the deposition given at said time and place by said witness; deposition was taken pursuant to stipulations hereinbefore set forth; deposition was taken by me in stenotype and transcribed by me by means of computer; deposition was provided to witness for examination and signature outside the presence of the Notary Public. I am neither a relative of any of the parties or any of their counsel; I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D) and have no financial interest in the result of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal of office at Cincinnati, Ohio this 2nd day of April, 2014.



My commission expires: December 4, 2015

ANN M. BELMONT, RPR
Notary Public - State of Ohio